GUIDANCE DOCUMENT
for
IMPLEMENTATION
of
COMMUNITY MIDWIFE EDUCATION in AFGHANISTAN

Prepared for:

Ministry of Health
Transitional Islamic Government of Afghanistan
Kabul

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Executive Summary

There is an alarming shortage of trained female health workers in Afghanistan who have the ability to care for pregnant women and newborns, and manage obstetrical complications. In order to reduce the staggeringly high maternal mortality ratio, there must be an aggressive initiative to train women to be competent midwives. These midwives must then be placed in an appropriate enabling environment that allows them to practice what they have learned.

The ***Community Midwife Education Expansion Program*** will support the establishment of training centers that have the capacity to train community midwives. These training centers will

- Be appropriately staffed and equipped hospitals and satellite health centers that are practicing according to the National Clinical Standards;
- Have trained and competent clinical trainers and preceptors who will lead the training process and the development of skills in individual students;
- Implement the national curriculum for community midwives;
- Support student midwives before, during and after their training; and
- Work with and within communities who understand and desire the professional services of the newly trained community midwives.

To achieve this vision, concerned parties from around Afghanistan came together in July, 2003 to review the recent experience with auxiliary/community education. This workshop, sponsored by the USAID-funded REACH and JHPIEGO/Maternal and Neonatal Health Programs, HealthNet International and UNICEF, provided a forum for discussing lessons learned as well as the appropriate path for expansion. The current document is the result of the presentations and deliberations of this workshop and serves as a map for the replication/expansion of HNI's Auxiliary Midwife Training Program to other areas of the country.

The workshop recognized that, while the ultimate goal is the improvement of the health of women, children and families, the more immediate **goal** is the development of competent, practicing community midwives through the **establishment of community midwife training centers**. It is the establishment of these centers that requires the immediate energy, expertise and attention of this community.

The key findings of the workshop, which are presented in this guidance document, included:

- Expansion of midwifery education requires a variety of technical inputs, which calls for the **formulation of a Midwifery Education Technical Support Unit** (METSU), composed of government, IMEI, and relevant agencies and NGOs. The METSU would in turn be a technical resource to all NGOs who are in the process of implementing midwifery education, regardless of funding source.
- Capacity building of the government and relevant government institutions must be parallel to the rapid expansion of services. The IMEI is the focal point for midwifery

education, both for the standard midwives and the community midwives. Substantial **support must be provided to the IMEI** (both at a national and a regional level) to enhance their ability to conduct training, accredit training centers and certify graduates.

- There is a persistent need to **clarify the designation and role of the community midwife as a skilled provider** of essential and emergency obstetric care services. Her role in the community and her linkages with both the community and health facility (both her own and those to which she would refer) must be further clarified to enable people to promote her services and implement her training.
- Midwives, especially community midwives, do not serve in isolation. They must be **part of the health system**, which includes functioning Basic and/or Comprehensive Health Centers, and hospitals to which they can refer emergency cases. As well, they must be seen as **integral to their communities**. Preparation of community midwives should occur in an environment of community networks, where women, families and communities, including community agents such as female CHWs and TBAs, see the community midwife as an essential provider of maternal and newborn health services. Therefore, geographic designation of expansion sites must be coordinated with complementary inputs into both clinical and community networks.
- **Proper student selection** will be fundamental to the success of the program. Communities should be educated about the roles of the community midwife and encouraged to nominate appropriate candidates based on certain criteria. Fundamental to the nomination of students is the need to assure community leaders, women and their families of the conditions under which the students will live and work during their course of study.
- According to the *National Policy of Human Resources Development for Health* (draft, June, 2003) the MOH requires that all **NGOs will "use the national standardized curricula**…" and "… shall not attempt to prepare categories of health care providers not approved". Therefore, the national curriculum for community midwives, a competency-based, skill focused curriculum, must be finalized and made available. The implementation of this curriculum and its methodology requires that implementing agencies understand the concepts of mastery learning, skill competency and appropriate supportive clinical supervision.
- **Clinical sites and clinical teachers must be prepared and supported** in a systematic manner that increases the likelihood of effective and efficient knowledge and skill transfer. It is clear that students learn what they see, thereby compelling teachers and clinical sites to be practicing according to the National Clinical Standards.
- **Student assessment must be ongoing, specific and directive**. It should include both knowledge and skill assessment, and be monitored by the use of student logbooks and skill tracking sheets.

Need for Trained Providers vs. Training Capacity

The need for trained midwives in Afghanistan is large, and the desire to rapidly increase the number of midwives is great. It is essential to recognize that a number of years will be required to achieve the ultimate goal of adequate midwifery coverage.

The number of students per training batch is determined by the capacity of the program to provide quality training. In order to succeed in developing skilled providers, with adequate experience and confidence, certain training principles must be adhered to. There must be a suitable student to teacher ratio for learning. As well, there must be an adequate number of cases in the training facility.

When the number of students exceeds the capacity of the system to train them it results in unqualified graduates, poor performance, wasted resources and frustrated health managers. Other countries have experienced this problem of rapid poor quality training of a large number of village midwives. These midwives had limited impact, and ultimately millions of dollars had to be invested to recall all the midwives for retraining. Afghanistan cannot run the risk of wasting its investment in the development of human resources

The process of expanding community midwife education will require the development of systems and processes, which extend from the national to the local level. It is the mission of the *Community Midwife Education Expansion Program* to provide the technical leadership necessary for successful implementation.

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GUIDANCE DOCUMENT for IMPLEMENTATION of COMMUNITY MIDWIFE EDUCATION in AFGHANISTAN

INTRODUCTION

For the successful expansion of midwifery services to all parts of Afghanistan, there is a need to increase both the quality and quantity of female health personnel who possess the necessary maternal and newborn health skills. This means that there must be competently trained midwives, working in both the hospitals and the health centers, who are able to provide comprehensive maternal and newborn care including:

- antenatal and postnatal care
- case and support during delivery, including newborn care
- diagnosis and management of common maternal and newborn emergencies (e.g. PPH, retained placenta, newborn asphyxia), especially those that frequently result in maternal or perinatal death,
- stabilize and refer cases that require advanced care (e.g. eclamptic fits, septic shock) and
- provide family planning and early newborn care.

As well, these midwives must work in an enabling environment in which there is adequate managerial support and clinical supervision. When both the skilled provider is available and the health care environment is functional the principle of skilled attendance for childbirth can be achieved.

Goal

The ultimate goal of community midwife education in Afghanistan is to prepare competent, compassionate community midwives who possess the skills to manage normal and problem pregnancies, including life threatening complications of pregnancy, in order to promote health and reduce maternal and newborn morbidity and mortality.

The **goal** of the Community Midwife Education Expansion Program is to develop a sufficient number of high quality community midwife training programs that will meet the needs of Afghanistan for rural providers of maternal and newborn health services.

Objectives

The objectives of the Community Midwife Education Expansion Program are to

- establish a framework for **successful expansion** of community midwife education to various parts of Afghanistan.

- put forth a single, uniform, **standardized national curriculum** for the education of community based midwives,
- support the **improvement of services** within hospitals and health centers to an acceptable level so that they may serve as clinical training facilities,
- provide training and implementation support to experienced clinicians (preferably midwives) who will serve as **clinical trainers** and preceptors,
- provide guidance for the **selection of students** for the community midwife program, and
- establish a safe and constructive **physical and educational environment** in which students may live and learn.

A substantial amount of the material in this document comes from the experience of HealthNet International (HNI), which pioneered the auxiliary midwife training[1] program in Ghani Khel/Jalalabad in June, 2002. Their work in the 5 years prior to inaugurating their program laid the foundation and created a platform for a sustained and successful initiative. The results of their first year of training experience was presented in a workshop in Kabul in July, 2003. Delegates to the workshop debated and discussed the lessons learned and put forth their thoughts and recommendations. These have been distilled and compiled here as a guide to implementation.

The process of preparation, education, certification, deployment and support of community midwives requires careful planning and implementation. This *Guidance Document* is meant to provide an operational framework for the successful and consistent expansion of this program on a national scale. Technical assistance for this implementation is expected to be made available to implementing NGOs[2] from a core Midwifery Education Technical Support Unit (METSU) whose members would include:

- Ministry of Health – especially the Human Resources Division and the Maternal Child Health Section
- Intermediate Medical Education Institute (IMEI)[3] – the certifying and accrediting body for community midwife education
- HealthNet International – who implemented the first curriculum
- USAID/REACH – who developed the competency based materials and has substantial experience in the learning approach on which the curriculum is based
- UNICEF – who has materially supported midwifery training in Afghanistan and actively participates in its expansion.

These agencies would form the METSU, whose role would be to guide the implementing NGO in how to prepare, conduct and monitor the training program.

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[1] The official name of these rural midwives is *community midwife*, to reflect their area of skill and focus, rather than auxiliary midwife, which suggests an ancillary role. As well, it is suggested that midwives prepared by IMEI be known as *midwives*, rather then professional midwives, so as to not assign an "unprofessional" designation to the community midwife.

[2] Given the demand for community midwives in the NGO sector, and the comparative advantage of NGOs to conduct this training, it is anticipated that NGOs with the appropriate clinical and community networks, in the geographic areas of priority, will be awarded grants

[3] At the recent HR Strategy Development Workshop (Jan '03) it was agreed that the IMEI name would be changed to the Institute for Nursing and Allied Health, although this has not yet officially taken effect.

GENERAL AND MANAGEMENT CONCERNS

Technical Support for Implementation

During the implementation process the implementing agencies may seek technical support from a core technical team. The provision of this technical support would be accomplished in a collaborative manner with government, local government institutions, international and technical agencies, and experienced NGOs, through the METSU (Midwifery Education Technical Support Unit) described above. Its role would be to guide the implementing NGO in how to prepare, conduct and monitor the training program. Initial support would be based on this document, while ongoing support may include:

- organizing or conducting knowledge update and clinical standardization courses
- technical support for service improvement (infection prevention, new clinical practices, etc.)
- organizing or conducting training skills courses
- orientation to the curriculum and learning resources
- modification of the course schedule and outline
- monitoring of student progress and development of competency.

Role of IMEI in Certification and Accreditation

The Community Midwife Education Workshop of July, 2003 came to the same conclusion as other groups; that the community midwife be certified by the IMEI and that the curriculum for preparing community midwives be accredited by the IMEI and endorsed by the Ministry of Health, Human Resources Directorate. In order to do this, the IMEI must develop a certification mechanism for graduates and be supported to accredit the community midwife education programs as they develop throughout the country.

Official sanction or recognition of these graduates will be critical for their success. As they are members of a new cadre, many people in the community will not be aware of their training or their scope of practice. Therefore, public and explicit endorsement of their role must be ensured, and all concerned Ministries and agencies must be made aware of this role.

As the community midwifery program grows, the IMEI should assume a greater role in the preparation and deployment of this cadre. Ultimately, the IMEI would expand its capacity to manage an ever widening array of responsibilities related to community midwife training, including:

- reviewing and assessing the quality of technical material related to midwifery,
- establishing a career path for the community midwife, which may include a conversion program for those community midwives who wish to have the midwife designation,
- developing continuing education or refresher training programs for community midwives,

- establishing certification mechanisms,
- undertaking review and accreditation procedures for other IMEI campuses and NGO training programs,
- developing, adapting and updating curricula,
- conducting the professional training of teachers and preceptors according to the concepts of competency-based clinical education,
- managing both the clinical and classroom component of clinical training, and
- conducting evaluations and impact assessments of the community midwifery program.

SCOPE OF WORK OF THE COMMUNITY MIDWIFE

The Designation of Community Midwife

To address the special needs of the rural areas of Afghanistan, a special initiative must be undertaken for the preparation of midwives to serve in the rural area. This means that the midwives should be selected from the community, and prepared for the community. Their midwifery education should be customized so that they learn how to serve the specific needs of the community.

The current centers (IMEIs) for midwifery training in Afghanistan are all in the major cities of the country: Kabul, Jalalabad, Kandahar, Herat and Mazar-I-Sharif[4]. It is difficult, given their educational focus and their urban location, to prepare women to work in rural areas. As well, both recruitment from and deployment to a rural area is difficult to achieve when training is in the city. Finally, there is currently great demand on these urban clinical centers in both the inservice (refresher) training of safe motherhood providers as well as the eventual preservice (formation) education of both doctors and midwives. This will cause crowding of these clinical training settings, limiting the clinical experience that will be passed on and made available to the community midwife student.

Given these factors, the development of *rural* training centers, along the model used by HNI for its inaugural program, is far more likely to produce a midwife well prepared for rural service.

While the selection of students and their eventual deployment may differ between the midwifery and the community midwifery program, the essential midwifery competencies do not differ between the two groups. It is as essential, and perhaps more essential, that the community midwife, who is posted alone at a peripheral service delivery point, possess the life saving skills needed to prevent a pregnancy complication from resulting in a maternal death.

The distinction between midwives and community midwives lies more in the focus of practice, rather then the scope of practice. Table 1 shows the differences in the two groups. This table shows that the core midwifery competencies are the same; the actual distinction lies only in their preparation, not their subsequent work. They are both midwives.

Consideration should be given to uniting them as a cadre, and having one designation of midwife, with two manners of preparation, and two areas of focus. The distinction between any two cadres should be based on their differing scope of work. Given that the scope of work and the skills are largely identical between these two groups, the impact of separating them should be carefully considered.

[4] The campuses of Kabul and Jalalabad IMEI are functional with respect to midwifery training, although Jalalabad is using an unapproved curriculum. All other IMEI campuses are not providing midwifery training at this time

Table 1. *Characteristics of midwife and community midwife*

Characteristic	Midwife	Community Midwife
Place of training	Urban	Rural
Area of clinical focus	Urban	Rural
Educational requirement	Class 12 education (for the next 5 years, class 9 will be acceptable for admission)	Class 9 education (for the next 5 years, class 6 will be acceptable for admission)
Length of education	2 academic years	18 months continuous
Competency-based approach to education	Yes	Yes
Scope of midwifery care (Essential Obstetrical Care and Basic Emergency Obstetrical Care)		
Childbirth education and birth preparedness	Yes	Yes
Antenatal care	Yes	Yes
Care during labor and birth	Yes	Yes
Normal newborn care	Yes	Yes
Post partum care	Yes	Yes
Family planning	Yes	Yes
Administration of parenteral antibiotics	Yes	Yes
Administration of parenteral oxytocic drugs	Yes	Yes
Administration of parenteral anticonvulsants	Yes	Yes
Intravenous therapy including fluid replacement	Yes	Yes
Assisted delivery (vacuum extraction)	Yes	Yes
Removal of placenta	Yes	Yes
Removal of retained products of conception	Yes	Yes
Newborn resuscitation	Yes	Yes
Infant (first year of life) care	No	Yes
General gynecologic care	Yes	Yes

Role of Community Midwife

The primary responsibility of the community midwife is to provide competent effective essential obstetrical care[5], including basic emergency obstetric care[6], to the community in the catchment area of the facility in which she works. To do so, she must not only be able to provide skilled care, but she must also:

- Understand the communities that she serves and their particular needs
- Work with communities to provide health education, especially birth preparedness and complication readiness,
- Facilitate the community's active participation in the health system (e.g. their local service delivery site, BHC, CHC, Hospital),Work with TBAs and female CHWs to identify pregnant women in the community

[5] EOC describes the elements of obstetric care for the mother and newborn needed for the management of normal and complicated pregnancy, delivery and the postpartum period.

[6] Basic EmOC encompasses the management of pregnancy complications including at least the following: intravenous therapy, including fluid replacement; administration of parenteral antibiotics, oxytocic drugs and anticonvulsants; assisted delivery (vacuum extraction); manual removal of placenta, and removal of retained products of conception (manual vacuum aspiration).

- Work with TBAs and female CHWs to facilitate both the access of pregnant women to skilled care and the access of skilled care givers to pregnant women
- Be familiar with the kinds of services offered in nearby hospitals for both emergent and non-emergent care, and how to access those services, and
- Be provided with appropriate clinical supportive supervision from facilities at the next higher level.

The community midwife works at the Basic Health Center (BHC) or Comprehensive Health Center (CHC) with a catchment area of 15,000 to 30,000 people (BHC) up to 30,000 to 60,000 people (CHC). The community midwife is meant to provide her services at the BHC/CHC with extensive outreach to the community.

In special circumstances, the community midwife may also work at the district hospital level and serve the community that surrounds the hospital. Her training and expertise more than adequately prepare her to work at this level.

Please also see the section on Community Participation, which describes activities to increase the participation of the community and their demand for services.

Geographic Focus of the Community Midwife Education Program

While the need for the services of the community midwife exists in all parts of Afghanistan, the preparation and deployment of these women must follow an orderly and logical progression. While they may be deployed to small BHCs and CHCs, their training must take place within a functioning clinical network of BHCs, CHCs, and a district hospital. This clinical network is essential not only for the training of the community midwife but also for her successful deployment.

The ideal places for the initial expansion of this program include those that have:

- Community support for the community midwife program and its goals,
- Functioning BHCs/CHCs, or a plan to prepare these as workplaces for the newly graduated community midwife,
- A functioning hospital which can serve as both a training center for the community midwife and a referral center for her upon her deployment,
- A health center or hospital with adequate case load per new community midwife to allow her to have sufficient practice to maintain her new skills (in the management of both normal and abnormal cases),
- A functioning community network where community mobilization efforts can take place, concurrent with midwifery training, in an effort to increase the community's demand for maternal health services,
- Community decision-making bodies, such as a *shura*, that can nominate candidates for community midwife training, and advocate for her upon her return,
- Availabile communication and transport services to support the needs of a training program, and
- An interested and motivated NGO to serve as the implementing partner for the training program.

STUDENT ISSUES

Student Selection

Proper selection of candidates for the community midwife program is vital to the success of the program. The criteria for selection must support the goals of the program and realistically evaluate the pool of applicants.

- ***Gender***: Female. Due to the extremely strong cultural preference for female birth attendants, and the need to provide a safe living and learning environment, only female candidates will be sought.
- ***Age***: Minimum age 18 years old, with older candidates being preferable. Age and experience impact significantly on the respect and support that a community will provide an applicant both as an applicant and eventually as a health care provider for the community. Communities are likely to support and encourage older women because they are more likely to have strong ties to the community.
- ***Marital status***: Married. It is preferable that the applicant be both married and have children. A community is likely to have greater respect for a woman who herself has given birth. Also a married woman with children is less likely to interrupt the training or service period for a pregnancy or birth. Furthermore, a woman who has already established her family is more likely to be able to immediately practice following completion of her education, rather than defer practice to complete her family.
- ***Community approval***: The ideal candidate for community midwife training is a woman chosen by the community, who is a member of the community and has significant ties to the community that she will serve. The woman must be acceptable to the community as someone that they would trust in seeking maternal health services.
- ***Educational background***: Able to read and write with a minimum of class 9 education. There is presently a limited pool of applicants who can meet this educational requirement. For this reason, in the next 3-5 years, women who are literate and have completed at least class 6 can be candidates for the program. To bridge this gap between desired and available levels of education, programs may consider developing accelerated learning or "bridging" programs to help appropriate candidates reach the minimal acceptable education level. These programs must be conducted separate from and before a student begins the community midwife program.
- ***Motivation***: The community midwife must be motivated and willing to work in rural areas of Afghanistan, which includes any agreement or concurrence necessary from the her husband or family. It is hoped that the candidate community midwife would commit to serving for a period of 5 years in the community that supported and sponsored her application.
- ***Mobility***: The community midwife must be able and willing to relocate to the training/clinical site for the full period of the educational program, i.e., 18 months. She and her family should be aware of breaks built into the schedule that allow her to visit her home and family, approximately every 5 months.

- ***Willingness to adhere to work conditions****:* The new graduate must be aware of and willing to work according to the anticipated schedule of a community midwife, meaning working in a BHC/CHC with other staff, and sometimes working out of normal working hours.

Student Issues During the Program

Recognizing that one of the objectives of the community midwife training program is to establish a safe and constructive physical and educational environment in which students may live and learn, certain issues must be considered.

Student hostel

A safe and appropriate hostel must be available and used during the training. This hostel must:

- Provide nursery facilities for those women who come with small children
- Have adequate security, including a night guard
- Have appropriate support staff, such as a cook and cleaners,
- Offer (free or for a reasonable cost) services such as laundry services
- Be able to provide escort service for women who may return from clinical duties late in the evening, and
- Be managed by a competent manager.

Transport

Since it is unlikely that all the appropriate learning arenas will be in a single place, there will be satellite clinical centers (such as BHCs, CHCs, or community or women's centers) where training may take place. Students must be provided appropriate transportation to those satellite sites.

Numbers of students

While the need for community midwifes may be the driving influence behind establishment and conducting of community midwife training, it cannot determine the number of students. Student number must be determined by the clinical, educational and physical capacity of the site, rather than by the need for a predetermined number of graduate community midwifes. This means that, if there is adequate clinical volume for only 20 students to effectively learn, then the class size should not exceed 20 students.

Increasing the number of students beyond the educational capacity of the training center will negatively impact the training of all students and may result in a poor quality training program with no competent graduates. In most situations it will be unlikely that a rural training facility will be able to accommodate more than 20 – 25 students per batch.

It must be kept in mind, given that the course is an 18-month program, that 2 batches of students may overlap for 6 months each year. If there are not adequate capacity or facilities for 2 batches at the same time, the NGO may consider running sequential 18-month courses, rather than always doing an intake at the same time each year. The program schedule can be adjusted to allow 2 concurrent batches of students, making allowance to prevent crowding in the clinical area.

Student incentives

In many societies, professional education itself, with its enhancement of an individual's personal, professional and financial potential, is sufficient incentive for a student. However, in a situation where some incentive must be provided to students, it may take both monetary and non-monetary forms. These include books and learning materials, clinical supplies and/or a clinical kit, promise of employment in a local NGO managed facility, stipend for home leave, etc.

COMMUNITY PARTICIPATION IN EXPANSION OF SAFE MOTHERHOOD SERVICES

Increasing Demand for Services of Community Midwives

It is necessary to not only train qualified providers and upgrade their clinical facilities, but also to ensure and promote the usage of the available clinical services. There must be an active partnership with the community to develop maternal and newborn health services that are desirable, available and acceptable. Implementing NGOs should have a functioning community network to enable them to easily link with the communities that they seek to serve.

Linkage with community

Health care providers and health care users should come together at the outset of service improvement initiatives to agree on the criteria that will be used to judge the success of service improvement. Using clinical criteria alone may result in the establishment of high quality services that the community refuses to use. Factors that must be considered include

- Respect for cultural beliefs of women
- Understanding of practices that encourage women to seek services
- Barriers and incentives that influence a decision to give birth in a facility with a skilled attendant

Quality of care

The International Planned Parenthood Federation notes 10 Rights of the Client or elements of quality of care. By striving for these we increase the likelihood (but do not ensure) that the community will seek the services offered. These quality of care elements include:

1. Information
2. Access
3. Choice
4. Safety
5. Privacy
6. Confidentiality
7. Dignity
8. Comfort
9. Continuity
10. Opinion

Experience has demonstrated that these quality of care elements are far more likely to be achieved when the community partners with the health facility and provider to improve services.

Linkage with Government and Non Governmental Agencies

There are numerous examples of how to use important social, cultural and religious events to inform the public about new or expanding services and how to access them. The power of social mobilization has been demonstrated by an international alliance known as "The White Ribbon Alliance for Safe Motherhood". Reports on their activities are available from the REACH office to inspire local agencies to undertake these kinds of events.

CURRICULUM AND TRAINING CONCERNS

Competency Based Clinical Curriculum

Competency-Based Training

The mastery learning approach to midwifery education assumes that *all* students can master (learn) the required knowledge, attitude and skills provided sufficient time is allowed and appropriate training methods are used. When training is competency-based the goal of the training is to ensure that the students possess the necessary competencies by the end of the program. Therefore, feedback must be continuous, comprehensive and explicit so that students have the ability to improve their performance until they achieve competency.

To accomplish this numerous tools and methodologies have been developed to facilitate skill development. These include the use of

- *anatomic models*, which allows for focused practice before entering the clinical arena
- *learning guides*, which detail all the specific steps (and their sequence, if necessary) that must be followed in a particular procudure
- *checklists*, which allow for specific and constructive feedback to students so that they may take directed corrective measures to improve their performance
- *clinical drills or simulations*, for practicing skills and management approaches for uncommon clinical scenarios (e.g. response to an eclamptic convulsion)
- *case studies*, for the detailed discussion of cases which allows trainers to follow and assess the students clinical decision making skills.

Need for Trained Providers vs. Training Capacity

The need for trained midwives in Afghanistan is large, and the desire to rapidly increase the number of midwives is great. It is essential to recognize that, if our ultimate goal is adequate midwifery coverage, a number of years will be required to achieve this.

The number of students per training batch is determined by the capacity of the program to provide quality training. In order to succeed in developing skilled providers, with adequate experience and confidence, certain training principles must be adhered to.

There must be a suitable student to teacher ratio for learning. Four students to one teacher is recommended for clinical learning, although 6 students to one teacher can be acceptable in certain circumstances. Increasing that ratio endangers patient safety as well as limits student learning and teacher effectiveness. A higher ratio can be used for classroom learning, but challenges are met during models practice if there are few teachers and many students.

There must be an adequate number of cases in the training facility. If there are too few cases then students do not develop their skills, nor have the possibility to see more unusual cases.

When the number of students exceeds the capacity of the system to train them it results in unqualified graduates, poor performance, wasted resources and frustrated health managers. Other countries have experienced this problem of rapid poor quality training of a large number of village midwives. These midwives had limited impact, and ultimately millions of dollars had to be invested to recall all the midwives for retraining. Afghanistan cannot run the risk of wasting its investment in the development of human resources

Learning Materials

Standardized Curriculum and Learning Resource Materials

A *Learning Resource Package for Community Midwife Education* has been compiled to provide a standard curriculum and set of learning materials to support the community midwife training program. The package is modeled on a competency-based approach to learning and draws on the experience of the auxiliary midwife training program implemented by Health Net International (HNI) at Ghani Khel in 2002.

Appendix 1 shows the proposed program content and structure.

Section One of the Learning Resource Package includes an introduction that explains the program rationale, and outlines the content and structure of the standardized program, including a list of the learning modules and a program calendar. *Section Two* provides a guide for the teachers responsible for implementing the program. *Section Three* contains the twenty-five learning modules, each of which includes: learning objectives, a detailed learning outline, relevant learning materials and assessment tools such as role plays, case studies, skills practice sessions, learning guides and checklists, clinical simulations, and knowledge assessment questionnaires.[7] Finally, *Section Four* describes the use of a clinical experience log book, a copy of which is to be provided to each learner. Teachers and learners will then be responsible for recording relevant information in the log book during and/or following practice at clinical sites.

To support the implementation of the activities included in the Learning Resource Package, the following reference manuals are available and strongly recommended, as they contain the majority of the technical content required for the training program:

- *Infection Prevention Guidelines for Healthcare Facilities with Limited Resources (JHPIEGO)*

[7] Much of the content in the package is adapted from JHPIEGO's *Learning Resource Package for Managing Complications in Pregnancy and Childbirth*, with the permission of: JHPIEGO Corporation. 2002. *Learning Resources Package for Management of Complications in Pregnancy and Childbirth: Notebook for Teachers*. Baltimore, Maryland. This Learning Resource Package was developed in collaboration with WHO to be a companion piece to the Managing Complications in Pregnancy and Childbirth.

- *Basic Maternal and Newborn Care (JHPIEGO)*
- *IMPAC: Managing Complications in Pregnancy and Childbirth: A Guide for Midwives and Doctors (WHO)*
- *IMPAC: Managing Newborn Problems (WHO)*

In addition, a folder of supplemental materials will be produced containing relevant theoretical content not included in the manuals mentioned above.

Local Adjustments to the Community Midwife Training Program

In different settings of Afghanistan there will be a need to make adjustments to the program. This will be particularly true for the program schedule and logistics. It is not anticipated that adjustments be made to the technical content, beyond some slight focus on regional or local health concerns, such as malaria, measles, etc. In fact, it is considered vital, and it is a strong desire of the MOH, that the clinical midwifery component of the training remain uniform and standard across the country.

Translation and Printing/Copying

It is important to recognize that the entire training package contains separate materials for students and teachers. They differ in that the teacher's materials contain the knowledge and skill assessment tools (answer sheets, checklists, etc.). These items must be managed and stored separate from each other.

Once the training package has been completed, it must be finally formatted, translated, printed and made available to each training program. Each training program must in turn produce sufficient copies of the materials for each trainer and each student. **All** participants must receive a personal copy of the key manuals and learning materials that they will use during the training *and* keep after the training. To train a midwife, then send her off to practice without having the needed reference materials to use during service, is to handicap her practice from the start. The student should receive her personal copy of the IMPAC manuals from the start, and use it, taking notes along the way, during the course of her education. She can then refer to this manual again and again during her work years to review information on less common complications.

A subset of the teacher's materials may be produced for the use of the clinical preceptors as well.

Teaching/Learning Facilities

In a clinical education program there are various learning arenas.

Classroom Facilities

Classrooms should be available for interactive presentations (e.g., illustrated lectures) and group activities. Seating in classrooms should be comfortable and lighting and ventilation

adequate. At a minimum, a chair and desk (with writing surface) should be provided for each learner, and a chalkboard and/or flipchart, chalk and/or felt pens, and an overhead projector should be available in each classroom. If available, there should be a video player and monitor to watch the various educational videos that are part of the program. Table 2 lists the supplies for training facilities.

Table 2. Supplies for Classroom Facilities at Training Centers

#	**Item Description**	**Quantity**
1	Overhead projector	1
2	Overhead screen	1
3	Flipchart stand	2
4	Flipchart paper	500 sheet
5	Marker for flipchart	4 color, 10 each
6	Transparency papers	2 box

If possible, classrooms should be within easy access of the clinical sites used for the program.

Simulated Practice Environment

A simulated practice environment, or learning lab, provides students with a safe environment where they can work together in small groups, watch technical videos, and practice skills with anatomic models. If a room dedicated to simulated practice is not available, a classroom or a room at a clinical practice site should be set up for this purpose.

The simulated practice environment must have the necessary supplies and equipment for the desired practice sessions. The room should be set up prior to starting the program and there should be enough space and enough light for them to practice with models or participate in other planned activities. The following resources should be available:

- anatomic models, (Table 3 below contains a proposed basic list of anatomic models for simulated learning labs).
- learning materials such as the reference manuals, learning guides and checklists,
- chairs, tables, a place for handwashing or simulated handwashing, video cassette player and monitor, flipchart stand, paper and markers, and
- medical supplies such as a newborn resuscitation bag and mask, cloth sheets or drapes, cotton/gauze swabs, syringes and needles, and infection prevention supplies.

Table 3. Supplies for Learning Labs at Training Centers

#	**Item Description**	**Quantity per 4 students**
1	Childbirth Simulator	1
2	Newborn Resuscitation model	1
3	Newborn ambu bag	1
4	Replacement face shields	2
5	Cervical effacement and dilation models	1
6	Fetus for vacuum delivery	1
7	Vacuum extractor	1
8	Zoe Gynecologic Simulator	1
9	MVA syringe sets.	2

It is in this site that students will learn the procedures first on anatomic models. This principle, called humanistic training, allows the student to learn the steps of a particular procedure (i.e., manual vacuum aspiration) in relative safety using anatomic models. This reduces stress for the learner as well as risk of injury and discomfort to the patient/client.

Clinical Training Facilities

Clinical training sites should be assessed and selected based on the following criteria:

- **Location:** Is the clinical facility in the appropriate catchment area?
- **Patient/Client mix and volume:** Are there sufficient patients/clients in sufficient numbers for learners to gain the clinical experience needed? It is suggested that for a training program with 20 – 25 students, the total clinical volume of the main training site and satellite training sites be approximately 300 – 400 deliveries per month.
- **Equipment, supplies and drugs**. Does the facility have the necessary equipment, supplies and drugs, in sufficient quantities, to support the learning process?
- **Staff**. Are staff members at the site willing to accept learners and participate in the learning process? Do they use up-to-date, evidence-based practices for pregnancy, childbirth and newborn care? Do their practices reflect the knowledge and skills described in this learning resource package? Is there a need to update their knowledge and skills? Do they use correct infection prevention practices?
- **Transportation**. Is the site within easy access for learners and teachers? Do special transportation arrangements need to be made? Is it in safe proximity to the student hostel?
- **Other training activities** Are there other training activities at the site that would make it difficult for learners to gain the clinical experience they need?

Once the clinical training sites have been selected, they will need to be prepared so that they are providing care according to the accepted national standard. See *Clinical Site Selection and Preparation* below for greater explanation.

Clinical Site Strengthening and Preparation

In order for students to learn the appropriate clinical skills, they must work in a clinical environment in which those clinical skills are practiced. If students learn one thing theoretically in the classroom, and see a different standard practiced in the clinical setting, they will adopt the practice that they see in the clinical setting. Therefore, it may be necessary for clinical sites that are selected to undergo a series of steps to upgrade clinical services to prepare to be suitable training centers. These steps may include:

- Infrastructure improvements: adequate water, space, waste disposal
- Provision of certain supplies and equipment: instruments, infection prevention supplies, linen, etc.
- Improvement in Infection Prevention practices: instrument processing, hand washing, housekeeping, patient care
- Service provider training in Best Practices: e.g., active management of third stage of labor, use of the partograph, use of magnesium sulfate for pre-eclampsia, etc.
- Support for implementation: problem solving the implementation of new practices such as MVA for incomplete abortion, etc.
- Management support for improved use of personnel, supplies, medications, etc.

Student Assessment

According to the principles of humanistic training described above, learners should first practice a new clinical skill using anatomic models. For interpersonal and decision–making skills, other methodologies are used. These include role-plays, case studies and clinical simulations. Once learners have had adequate practice, including coaching and feedback from their teacher, and before practicing a skill with patients/clients, they are assessed using one of these methodologies.

Ideally, learners will then continue to practice these skills with patients/clients until they are able to demonstrate competency in the clinical setting. This final assessment of competency with patients/clients is necessary before they can perform a skill without supervision. Ongoing practice and assessment with patients/clients may not, however, be possible for all of the skills needed to provide high quality care during pregnancy and childbirth.

A realistic guideline to follow is that most, if not all, skills associated with normal maternal and newborn care should be assessed with patients/clients, while skills that are rarely required should be assessed using other methodologies, such as clinical simulations. Nonetheless, if there are opportunities to practice these rare skills and be assessed with a patient/client, they should be taken.

The continuing assessment of students in a long term (18 month) program such as this requires methodical assessment and record keeping. Each student should have an individual student file, in which is kept copies of:

- The result of knowledge assessments, such as end-of-module questionnaires or case studies,
- Clinical skill ckecklists, which detail the skill acquisition and skill competency stages of skill development, and
- Overall assessments of student progress.

Clinical Experience Logbook

As well, students keep a clinical logbook. During clinical practice, learners must record activities/experience in the relevant sections of their Clinical Experience Log Book, on a daily basis. This will include information on the births attended, the application of specific skills, and a weekly case study of a client/patient for whom care has been provided (during blocks of clinical practice). Where possible, the case studies should focus on the management of complications in pregnancy and childbirth.

Trainer and Preceptor Preparation

Any midwife training program must begin by identifying adequate number of qualified female staff, who are willing and interested in training. This will be a challenge, given that it is recognized that there is a lack of experienced midwives to serve as service providers, let alone as trainers.

Clinical Preparation

Once recruited, inservice training may be needed to help ensure that all clinical teachers and preceptors are:

- current in their knowledge of maternal and newborn health care
- standardized in their clinical skills related to maternal and newborn health,
- able to use competency-based learning methods and methods of assessment,
- capable of serving as role models for learners and colleagues.

These courses are known by the names *Knowledge Update and Clinical Skills Standardization in Emergency Obstetric Care*, and *Clinical Training Skills Course for Maternal and Newborn Health Trainers*.

In the *Knowledge Update and Clinical Skills Standardization*, participants review the current evidence for best practices in maternal and newborn health, with special emphasis on standardized management of obstetric complications. The technical information in the course comes from the WHO IMPAC Manual, *Managing Complications in Pregnancy and Childbirth*, which is used extensively throughout the course. In this segment knowledge is transferred via illustrated lecture, discussion, use of role play and case study, and it is assessed using a multiple choice knowledge questionnaire.

Participants then work extensively with anatomic models to standardize skills, using learning guides, which break the accepted standard into discrete steps. The rationale of

learning a standardized approach is that it makes the process more explicit and facilitates the teaching of the material to other learners.

Once they have become competent on the models, as judged by the use of skill checklists, they move to the clinical area where they apply what they have learned. Again, the participants are coached by the trainers and assessed using the checklists.

By participating themselves in a formal process of both clinical and training preparation these trainers will understand the competency based learning process much better.

Developing Training Skills

Both clinical trainers and clinical preceptors are needed for successful clinical training in maternal and newborn health. Therefore, after all these practitioners have their skills updated and standardized, and they have become proficient in the new skills they have developed, they should participate in a Clinical Training Skills course to give them the training skills to facilitate the transfer of knowledge and skills. Some may in fact need only an abbrieviated course to give them the skills to be effective preceptors. These skills would include how to:

- give an effective demonstration
- use learning guides and checklists
- effectively use models in clinical skill development
- give supportive feedback, and
- manage hospital-based or clinic-based practice.

A trainer, on the other hand, needs all of the above, plus skills the ability to

- create a positive learning environment
- effectively use audiovisual aids
- present a interactive illustrated lecture.

In order to maximize the chance that these new midwives will posses the skills they need at the conclusion of the course both trainers and clinical preceptors must be available and appropriately skilled.

Course Coordinator

Each program will need a designated Course Coordinator. It is preferred that the coordinator be a midwife, who is from the area where the program is established. She should make an initial orientation visit to Ghani Khel to work with the training team there to understand the process.

SUPERVISION AND MONITORING

Supervision of Training

Each Community Midwife Training Program will be supported by periodic supervision from the METSU. This supervision is meant to provide the program with the technical advise necessary to achieve success. It can also help programs monitor their progress towards expected goals and outcomes.

Program supervision will work with training staff, especially the Course Coordinator and Clinical Teachers to assess and improve their skills in

- educational management,
- clinical case management,
- teaching and training,
- student assessment, and
- record keeping and student monitoring.

Clinical Supervision and Support to New Graduates

Training environments frequently receive more attention toward improving their clinical services so as to enable more effective and efficient learning, as well as providing an environment that demonstrates the "correct" principles of patient care. The newly graduated community midwife's own clinical environment, however, is typically less ideal, and presents challenges in service delivery previously not encountered during training. If the newly graduated midwives are not able to overcome these challenges, and quickly begin the process of providing services to patients, these new clinicians can loose confidence and their effectiveness can be limited. While midwifery training may be competency-based and effective, it alone is not sufficient to allow a provider to apply in the local setting what she has learned in the training setting. Development of a sufficient repertoire of clinical skills is a progressive process that starts during training and continues after the training as well. Table 4 shows the progression of clinical skill during and after training.

Table 4. Increasing Levels of Clinical Skill and Effectiveness

Skill level	**Definition**	*How to achieve*	**When to achieve**
Skill acquisition	Ability to perform a new skill, but *with assistance*	Use of anatomic models and competency-based training methods	During the initial portions of a training program
Skill competency	Ability to perform a new skill	Coaching in the training clinical environment with patients	During the clinical practice portion of a training program
Skill proficiency	Ability to *efficiently and confidently* perform a new skill	Supervision in the provider's own clinical environment	*After* a training program, through appropriate clinical experience

Effective clinical supervisors must support new providers to help them gain clinical confidence and skill proficiency. To support this transition the frequency of these supervision visits should be greater in the first months after students graduate from their training programs.

The role of the clinical supervisor

Often supervision is misconstrued as monitoring, or administrative supervision, meaning the logging of hours of attendance and completion of tasks. *Clinical* supervision, while it does not exclude administrative necessities, focuses on improving the provider's *performance*. Effective clinical supervision:

- promotes the transfer of learning from the academic (learning) setting to the work (application) setting,
- facilitates a problem-solving approach regarding clinical issues such as infection prevention, client-flow, etc.,
- builds the clinical confidence of the new provider by offering direct coaching and mentoring,
- helps ensure adequate supplies/equipment/medications needed to perform her functions, which the new provider may be timid and reluctant to press the management system to provide,
- identifies areas for skill strengthening (which can feed back to the training itself),
- limits deterioration of new skills by showing ways to maintain rarely used skills,
- promotes a mentoring relationship with the clinical supervisor, rather than solely an administrative one,
- assists the new provider to integrate into the team of co-workers as a highly trained clinician with a new role (which often in Afghanistan has gone unfilled for many years)[8], and
- helps the provider create appropriate linkages with the nearby referral point.

To be effective the clinical supervisor must:

- be proficient in the clinical skills that the new provider is applying,
- have training or coaching skills to effectively support the new provider to gain clinical confidence,
- understand the system and environment in which the provider is working, and
- be patient and humble so as to be truly supportive in the challenging environment the new provider faces.

[8] Given that the community midwife is a newly designated position and that community midwives will be female, it will be important for her to be recognized by her community and colleagues as a competent provider of necessary services.

Appendix 1

PROGRAM CONTENT AND STRUCTURE

Recommended Learning Modules

The following learning modules include the theoretical content and clinical skills considered to be necessary to prepare community midwives capable of providing comprehensive maternal and newborn care. The modules are divided between the three twenty-six week phases of the training program, as described below, and the essential competencies expected to be achieved by the end of the training program are included in Textbox 1, following the modules.

Each module is self-contained and includes a learning outline and a multiple-choice knowledge assessment questionnaire, which is to be administered on completion of the module. In addition, where applicable, learning guides, skills checklists, role plays, case studies, and clinical simulations are included (for details, see Section Three of this learning resource package).

Phase 1: Introductory Topics and Normal Pregnancy and Childbirth Care (26 weeks)

Phase 1 includes Modules 1 through 11 of the program. The first seven of these modules provide an introduction to a range of topics that underpin midwifery training. Many of these topics will be elaborated on in later modules so as to relate specific theoretical content to the learning of particular clinical skills. For example, Module 4 introduces learners to basic anatomy and physiology and Module 5 provides an introduction to the physiological changes that take place during pregnancy. This basic and/or introductory information is then expanded on in later modules; for instance, at the beginning of Module 9, which covers normal childbirth care, the physiology of labor is included. In addition, Phase 1 includes modules on normal antenatal and postpartum care and newborn care.

Module 1: Orientation
- Introduction to the training program
- Visits to health facilities

Module 2: The Role of the Community Midwife
- The midwife in the community
- Safe motherhood and midwifery
- Maternal and newborn health in Afghanistan
- The sexual and reproductive rights of women

Module 3: Basic Nutrition
- General nutrition
- Nutritional problems in Afghanistan
- Nutritional needs during pregnancy

- Nutritional needs of the newborn and small children

Module 4: Basic Anatomy and Physiology
- Overview of systems
- Male and female reproductive systems
- Vital signs (temperature, pulse, respiration, and blood pressure)

Module 5: Change and Adaptation in Pregnancy
- Physiological changes in the reproductive system
- Changes in other systems (cardiovascular, urinary, endocrine)
- Skeletal, skin and breast changes
- Detecting pregnancy

Module 6: Foundations of Basic Maternal and Newborn Care
- General principles of basic care
- Overview of key skills for basic care (interpersonal communication, problem solving, infections prevention practices, record keeping)
- Principles of medication and vaccine administration (including preparation and routes of administration) and giving injections

Module 7: Infection Prevention
- Personal and communal hygiene
- Infection prevention practices for health care providers

Module 8: Antenatal Care
- Introduction to antenatal care
- The basic antenatal visit (assessment, including history, physical examination, pelvic examination, confirmation of pregnancy, and calculation of EDD; care provision, including birth planning, preventive measures and health education and counselling)
- Common discomforts in pregnancy
- Special needs (including malaria, anaemia, HIV, and gender based violence)

Module 9: Childbirth Care
- Normal labor and childbirth (including the physiology of labor and diagnosis and confirmation of labor)
- Introduction to childbirth care
- Basic care during labor and childbirth (including use of the partograph, clean and safe delivery, active management of third stage, IM injections, and episiotomy and repair)
- Common discomforts
- Special needs

Module 10: Newborn Care
- Introduction to newborn care
- Basic care of the newborn (including thermal protection, newborn resuscitation, eye care, early and exclusive breastfeeding, physical examination, and newborn immunization)

Module 11: Postpartum Care
- Physiological changes in the puerperium
- Introduction to postpartum care
- The basic postpartum visit
- Common discomforts
- Special needs (including malaria, anaemia, HIV, gender based violence, and postpartum depression)

Phase 2: Complications of Pregnancy and Childbirth (26 weeks)

Phase 2 includes Modules 12 through 22, covering the common complications of pregnancy and childbirth, including the postpartum and neonatal periods. The modules begin by providing information aimed at helping learners understand the physiology and/or pathophysiology relevant to a particular complication, followed by the skills needed to detect and manage the complication.

Module 12: Vaginal Bleeding in Pregnancy and Labor
- Understanding bleeding in pregnancy and labor
- Detecting and managing vaginal bleeding in early pregnancy
- Detecting and managing vaginal bleeding in later pregnancy and labor
- Rapid initial assessment and management of shock (including taking blood samples, starting an IV, bladder chatheterization)
- Blood transfusion
- Manual vacuum aspiration (MVA)

Module 13: Vaginal Bleeding After Childbirth
- Understanding bleeding after childbirth
- Detecting and managing vaginal bleeding after childbirth
- Manual removal of placenta
- Vaginal and cervical inspection
- Repair of perineal, vaginal and cervical tears

Module 14: Headaches, Blurred Vision, Convulsions or Loss of Consciousness, Elevated Blood Pressure
- Understanding pre-eclampsia and eclampsia
- Detecting and managing pre-eclampsia and eclampsia
- Anticonvulsive and antihypertensive drug administration

Module 15: Unsatisfactory Progress in Labor
- Understanding obstructed labor
- Detecting and managing unsatisfactory progress in labor
- Vacuum extraction

Module 16: Malpositions and Malpresentations
- Understanding malpositions and malpresentations
- Detecting and managing malpositions and malpresentations

- Breech delivery

Module 17: Shoulder Dystocia
- Understanding shoulder dystocia
- Detecting and managing shoulder dystocia

Module 18: Labor With an Overdistended Uterus and a Scarred Uterus
- Detecting and managing labor with an overdistended uterus
- Managing labor with a scarred uterus

Module 19: Fetal Distress in Labor and Prolapsed Cord
- Understanding fetal distress in labor
- Detecting and managing fetal distress in labor
- Understanding prolapsed cord
- Detecting and managing prolapsed cord

Module 20: Fever During Pregnancy and Labour and After Childbirth
- Understanding fever during pregnancy and labour and after childbirth
- Detecting and managing fever during pregnancy and labour and after childbirth (including administration of antibiotics)

Module 21: Other Complications in Pregnancy and Childbirth
- Detecting and managing abdominal pain in early pregnancy
- Detecting and managing abdominal pain in later pregnancy and after childbirth
- Detecting and managing difficulty in breathing in pregnancy
- Detecting and managing loss of fetal movements
- Detecting and managing premature rupture of membranes

Module 22: Care of the Sick Newborn
- Assessment of the newborn with a problem
- Managing breathing difficulties, convulsions or spasms, jaundice, diarrhoea, and vomiting
- Measuring body temperature in the newborn
- Measuring blood glucose
- Insertion of gastric tube

Phase 3: Family Planning and Other Topics (26 weeks)

Phase 3 includes Modules 23 to 25, covering family planning, which is a vital component of midwifery care, infant care up to the age of one year, and essential information relevant to professional issues in midwifery.

Following completion of the modules included in Phase 3, time will be allocated to the revision of the modules on normal pregnancy, childbirth, postpartum and newborn care in Phase 1 and all of the modules on

complications in Phase 2. The revision of these modules will be integrated with periods of practice at clinical sites to provide learners with opportunities to consolidate learning and undergo final skills competency assessments.

Module 23: Family Planning

- Family planning in the context of Afghanistan
- Modern methods of family planning and their benefits and side effects
- Family planning counselling
- IUD insertion

Module 24: Infant Care

- Growth monitoring
- Nutrition in the first year of life
- Immunization in the first year of life
- Detecting and managing common health problems in the first year of life

Module 25: Professional Issues in Midwifery

- Supervision and management
- Ethics
- Continuing education
- Preparing to begin fulltime work as a community midwife at a designated facility

Textbox 1: Essential Competencies for Basic Midwifery Practice[9]

Competency 1: Midwives have the requisite knowledge and skills from the social sciences, the public health sector and ethics that form the basis of high quality, culturally relevant, appropriate care for women, their newborns, and their families.

Competency 2: Midwives provide high quality, culturally sensitive health education and family planning services in the community in order to promote healthy family life, planned pregnancies and positive parenting.

Competency 3: Midwives provide high quality antenatal care to maximize the woman's health during pregnancy, detect early and treat any complications which may arise and refer if specialist attention is required.

Competency 4: Midwives provide high quality, culturally sensitive care during labor, conduct a clean, safe delivery, give care to the newborn, and manage emergencies effectively to prevent maternal and neonatal mortality and morbidity.

Competency 5: Midwives provide comprehensive, high quality, culturally sensitive postnatal care for women.

Competency 6: Midwives provide high quality care for the newborn infant and surveillance and preventive care for the young child.

[9] World Health Organization, *Competencies for Midwifery Practice (Adapted from the Provisional Competencies for Basic Midwifery Practice Prepared by the International Confederation of Midwives, 1999)*.

Recommended Program Calendar

The following program calendar reflects the structure of the training program for each of the three phases. In **Phase 1**, Modules 1 through 11 are covered during the first thirteen weeks and include classroom activities (e.g. illustrated lectures and discussions, role plays, case studies, etc.), simulated practice of clinical skills, and short periods of supervised practice at clinical sites. For example, the module covering antenatal care is spread over three weeks and includes classroom and skills learning activities integrated with periods of supervised practice in antenatal clinics.

Weeks 14 through 23 of Phase 1 are spent in supervised practice at various clinical sites. During this period, learners should be rotated through the sites so as to enable them to practice the full range of skills learned during Phase 1. When scheduling periods of supervised practice, it will be important to avoid overcrowding clinical sites by assigning only small groups of learners to each of the sites used for the training program. In addition, it will be important to ensure that learners are provided consistent and appropriate clinical supervision while at clinical sites.

On the last day of Week 23 a comprehensive knowledge assessment is included, based on a selection of the questions from the knowledge assessment questionnaires for Modules 1 through 11. The aim of this comprehensive knowledge assessment is to enable teachers to determine student progress and identify ongoing individual learning needs.

A break of three weeks is scheduled at the end of Phase 1, although these three weeks can be worked in at other times, providing that learning is not disrupted unnecessarily.

Phase 2 covers the second 26 weeks of the training program and is structured in much the same way as Phase 1. Classroom activities, simulated practice of clinical skills, and short periods of supervised practice at clinical sites are scheduled during the first 14 weeks, covering Modules 12 through 21. Weeks 15 to 23 are then spent in supervised practice at various clinical sites and/or simulated practice, based on individual needs. At clinical sites, emphasis should, where possible, be placed on detecting and managing complications of pregnancy and childbirth. Learners should be rotated through the clinical sites to provide opportunities to practice the range of skills learned thus far.

Once again, a comprehensive knowledge assessment is included on the last day of Week 23, in this instance based on a selection of questions from the knowledge assessment questionnaires included in Modules 12 to 21.

As is the case with Phase 1, a break of three weeks is scheduled at the end of Phase 2 and these three weeks can also be worked in at other times, providing that learning is not disrupted unnecessarily.

Phase 3 covers the third and final 26 weeks of the training program and differs slightly in structure to Phases 1 and 2. Weeks 1 and 2, for example, cover the remaining two clinical modules in the program and include classroom activities, simulated practice of clinical skills, and several days of supervised practice at clinical sites. The final non-clinical module is then covered in week 3. Weeks 4 through 15 include review of the clinical modules included in Phases 1 and 2 of the program and will involve classroom activities, simulated practice of clinical skills, based on the individual needs of learners, and supervised practice at clinical sites (see Section Two: Guide for Teachers for further information about conducting review sessions). Weeks 16 through 24 are then spent entirely in supervised clinical practice during which learners should be assigned to clinical sites based on individual needs. For example, learners who need to develop further their competency in the skills for antenatal care should be assigned to an antenatal clinic for at least part of this clinical block.

The final comprehensive knowledge assessment is scheduled for the first day of Week 14 and is based on a selection of questions from the knowledge assessment questionnaires for Modules 1 through 25. Once again, this comprehensive knowledge assessment will enable teachers to assess the progress of learners and address individual learning needs during the final weeks of the program.

During Week 25 of Phase 3 final assessments of skills competency should be completed and, during Week 26, any remaining details relevant to completion of the program should be addressed.

Finally, it should be noted that English language classes are incorporated throughout all three phases of the training program, twice weekly during the weeks prior to the blocks spent in supervised clinical practice.